PRINTED: 09/23/2021 FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _				
TN4719		B. WING	B. WING		C 09/09/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
WEST HILLS HEALTH AND REHAB  KNOXVILLE, TN 37919						
PREFIX (EACH DEFICIENC	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)  (X5)  COMPLETE  DATE		
N 000 Initial Comments		N 000				
A Focused Infection (complaint investigation TN00055063 were concluded the second tealth and Rehab on the second tealth deficiences were second to the second tealth teal	A Focused Infection Control Survey and complaint investigations TN00055110 and TN00055063 were conducted at West Hills Health and Rehab on 9/7/2021-9/9/2021. No health deficiences were cited under 1200-8-6. Standards for Nursing Homes.					

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE